



703 N. Hancock Odessa, Texas 79761
Phone: 432-580-4500 • Fax: 432-580-7930
E-mail: mcole@westtexasreproductive.com
Web site: www.westtexasreproductive.com

This document will be completed entirely by you and will provide a personal history of yourself that will be given to the ovum recipients. The recipients may some day give this document to any child(ren) that may result from your donated egg(s). While not every couple will choose to disclose this information to the child(ren), all parents want to be able to provide accurate medical information. If children are told that they are born through your donation, the information contained within this document may be very important for them for medical and psychological reasons. It is for these reasons that we ask you to answer each question as carefully and thoroughly as you are able. All information requested is voluntary and will remain anonymous. A copy of this history form will be given to the recipients but will exclude personal information such as name, address, and social security number.

Donating your eggs is a caring and generous act, given in spite of some risk and discomfort. Those couples who receive eggs feel deep gratitude and respect for the gift you give so willingly. Naturally, most recipients and their children want to know as much as possible about the medical history of the woman who made their family possible. Thank you for letting them know you a little better.

When submitting your completed personal history form, please include a recent photograph of yourself. Photographs are an additional tool used in matching a donor with a recipient couple. Photographs are shared with the recipient. You may submit your personal history form and photo to **West Texas Reproductive Center** at the above address. Do not hesitate to call us for further information.

I certify that the following answers are truthful and accurate to the best of my knowledge and that I have included all pertinent information.

Signed: _____

Egg Donor Personal History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone 1st Choice: (_____) _____ hm wk

Telephone 2nd Choice: (_____) _____ hm wk

E-mail address: _____

Date of Birth: _____

Where did you see our ad? _____

Who referred you to our program? _____

Do you have insurance? _____

Married _____ Single with relationship _____ Single without relationship _____

Social Security Number _____ - _____ - _____

I the undersigned acknowledge that the following answers are accurate and truthful to the best of my knowledge and included all relevant information.

Signature: _____ Date: _____

Please send a photograph of yourself along with this questionnaire.

Attach Photo Here

Physical Characteristics

Age: _____ Year of Birth: _____ Height: _____ Weight: _____

Race: _____ Place of Birth: _____

Please describe your family's ethnic background/heritage: _____

Religion born into: _____ Are you adopted? yes no

What celebrity do people most commonly say you look like? _____

Please circle appropriate response

Body Type/Bone Structure:	small	medium	large		
Hands:	right-handed	left-handed	ambidextrous		
Eyes:	• color	brown	hazel	green	blue
	• set	narrow	average	wide	
	• size	small	average	large	
	• shape	round	oval	almond	
	• shade	light	medium	dark	
Hair:	• natural color	blond	brown	black	red other _____
	• color as a young child	blond	brown	black	red other _____
	• shade	light	medium	dark	
	• type	straight	wavy	curly	
	• fullness	thin	medium	thick	
	• texture	fine	medium	coarse	
Nose:	• size	small	medium	large	
	• width	narrow	average	wide	
	• length	short	average	long	
	• nostril flare	small	average	wide	
Cheekbones:	• set	low	average	high	
	• prominence	slight	medium	strong	
Mouth:	• size	small	average	large	
	• lips	thin	average	full	
Chin:	• shape	square	oval	round	
	• prominence	slight	average	strong	
	• cleft	none	slight	medium	strong
Skin:	• tone	light	med-light	medium	med-dark dark
	• tan ability	none	slight	medium	easy
	• condition	oily	medium	dry	combination
	• acne	none	slight	medium	severe at what age ____
Other Facial Features:	• moles	none	one	several	numerous
	• freckles	none	several	moderate	numerous
	• dimples	none	slight	medium	deep
Eyesight:	• vision	normal	far-sighted	near-sighted	
	• glasses	none	single	bifocal	trifocal
	• astigmatism	yes	no	age diagnosed _____	
Dental:	• device	none	braces	retainer	other _____
	• reason	cosmetic	accident	disease	other _____
	• age during use _____ to _____		years of age		
Other:	• list _____				
	• reason/cause _____				

Describe your family by the following physical characteristics:

	Eye Color	Hair Color	Complexion	Height	Body Type/Weight
Mother					
Father					
Brothers 1.					
2.					
3.					
Sisters 1.					
2.					
3.					

Personal Characteristics

Level of Education:

Completed grade school: _____ Completed high school: _____ GPA: _____
_____ Currently in college, pursuing a degree in: _____ SAT score: _____
_____ Completed college, degree in: _____ ACT score: _____
_____ Currently pursuing an advanced degree in: _____
_____ Completed an advanced degree in: _____

Current Job Title: _____

Languages: Speak: _____
Read: _____
Write: _____

Athletic Activity: (Circle appropriate choice):

athletic active average inactive

What physical activities do you engage in? _____

Have you excelled in any physical activities? _____

Manual Dexterity:

dexterous average clumsy

What manual skills do you have? _____

What have been your achievements as an adult? _____

What other skills or talents do you have (e.g., painting, writing, reading, ability to do games, crossword puzzles, handcrafts, etc.) Please describe: _____

Musical Ability:

musical average tone deaf

Voice: soprano alto tenor baritone bass

Instrument: _____ years of experience

Other: _____ years of experience

Reproductive History

Age at first period: _____ Are your cycles regular? _____

Interval between periods: _____

Pregnancy History

Year	Outcome	Any Complications
------	---------	-------------------

Did your mother take DES while she was pregnant with you? _____

Have you ever been diagnosed with infertility? _____

Explain: _____

Medical History

Allergies (food, pollen, bee stings, medications, etc.) _____

Describe childhood allergies you have outgrown: _____

Do you have any medical illnesses (asthma, diabetes, seizure disorders, etc.?) _____

What are your bleeding tendencies: do you have frequent nose bleeds, bleeding gums when you brush your teeth, and/or menstrual periods with blood clots? _____

Type of birth control used: _____

List the drugs, prescriptions and non-prescriptions, that you take regularly: _____

Any other medicines taken in the last 5 years: _____

Do you smoke cigarettes? _____ How much? _____
Do you consume alcoholic beverages? _____

If yes, how many drinks (beer, wine, alcohol) do you consume per day? _____ week? _____ month? _____
Have you ever used any kind of mind-altering drugs such as marijuana, LSD, heroin, or cocaine? _____
If yes, please give details and state last date used: _____

Have you ever used neuroleptic agents (tranquilizers, valium, thorazine, etc.) or anti-depressants? _____
If yes, please give details and state last date used: _____

Have you been sexually active during the past 6 months? _____

Are you currently sexually active? _____

Are you in a monogamous relationship? _____
If, no, then the number of partners you have been sexually active with over the past 6 months? _____

Have you or a partner of yours ever had a sexually transmitted disease (gonorrhea, syphilis, hepatitis, Chlamydia, herpes, condyloma, or trichomoniasis)? _____ Describe your diagnosis, year and treatment: _____

Have you received a blood transfusion within the last 12 months?

Have you been exposed to radiation or toxic chemicals in your work or personal life? _____

Have you received a bite from an animal suspect for rabies within the last 6 months? _____

Have you ever had eye surgery? _____ If yes, describe: _____

Have you been told of any gynecological problems (endometriosis, fibroids, ovarian cysts, abnormal Pap smears, etc)? _____

Have you ever received treatment by pituitary-derived human growth hormone? _____

Family Health History

	Age (if living)	or Age at Death	Medical problems or cause of death
Mother			
Father			
Brother: 1.			
2.			
3.			
4.			
5.			
Sister: 1.			
2.			
3.			
4.			
5.			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Children: (if any)			
1.			
2.			
3.			
4.			

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
HEART				
A. stroke				
B. heart attack				
C. heart disease				
D. hardening of the arteries				
E. high blood pressure				
F. heart condition from birth				
BLOOD				
A. anemia				
B. sickle-cell anemia				
C. hemophilia or other bleeding problem				
D. leukemia				
E. immune deficiency				
F. other blood disorder				
RESPIRATORY (LUNGS)				
A. asthma				
B. emphysema				
C. tuberculosis				
D. lung cancer				

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
GASTRO-INTESTINAL				
A. ulcer of stomach or duodenum				
B. gall stones				
C. hepatitis A (infectious)				
D. hepatitis B (serum)				
E. cirrhosis				
F. colon cancer				
G. ulcerative colitis				
H. Crohn's disease				
I. cystic fibrosis				
J. intestinal cancer				
K. any other cancer/problem of digestive system				
METABOLIC/ENDOCRINE				
A. diabetes mellitus				
B. hypoglycemia				
C. thyroid cancer				
D. thyroid disease				
E. goiter				
F. adrenal dysfunction or disorder				

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
URINARY				
A. kidney disease				
B. other disease of urinary tract (urethra, bladder, ureter)				
GENITAL/REPRODUCTIVE				
A. undescended testicle				
B. hypospadias				
C. prostate cancer				
D. uterine fibroids				
E. ovarian cysts				
F. cancer of cervix, ovaries or uterus				
NEUROLOGICAL				
A. Migraines (severe enough to seek treatment)				
B. mental retardation				
C. Dementia before age 50				
D. Multiple Sclerosis				
E. Cerebral Palsy				
F. epilepsy				
G. hydrocephalus				
H. disorder of the spinal cord				
I. Huntington's' chorea				

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
NEUROLOGICAL (CONT.)				
J. Gaucher's disease				
K. Wilson's disease				
L. Creutzfeldt-Jacob disease				
M. Alzheimer's disease				
N. other diseases of nervous system				
O. Parkinson				
P. hyperactivity				
MENTAL HEALTH				
A. schizophrenia				
B. bipolar or manic-depressive				
C. depression				
MUSCLE/BONE/JOINTS				
A. muscular dystrophy				
B. other chronic muscle disease				
C. lupus				
D. deformity of the spine				
E. osteoporosis				
F. dwarfism				
G. hereditary low back disease				
H. arthritis				
I. gout				

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
SIGHT/SOUND/SMELL				
A. deafness before age 60				
B. deformity of the ear				
C. cataracts before age 50				
D. blindness				
E. color blindness				
F. glaucoma				
G. deviated septum				
H. other sight/sound/smell disorder				
SKIN				
A. acne				
B. eczema				
C. skin cancer				
D. pigmentation disorders				
E. other disorders of the skin				
OTHER				
A. alcoholism				
B. drug abuse, misuse or addiction				
C. breast cancer				
D. any other cancer not mentioned above				

Family Health History (Cont.)

Please read the following list of medical problems carefully and indicate which ones you or one of your relatives have had. Please consider each condition carefully for each family member.

<i>Medical Condition</i>	<i>You or other family relative</i>	<i>Relationship (e.g. brother, maternal grandmother)</i>	<i>Age of diagnosis</i>	<i>Details of Diagnosis and treatment</i>
OTHER (CONT.)				
E. any other condition not mentioned above				
F. unexplained fevers within the last 3 months				

Has any member of your family, including yourself, had a problem or defect at birth of any of the following body systems?

1. Bones, muscles, joints, limbs
2. Gastrointestinal system
3. Nervous system, brain, spinal cord
4. Blood circulation
5. Respiratory system
6. Organ (heart, lung, kidney, etc.)
7. Genital/urinary
8. Metabolic hormones, enzymes, etc.

No _____ Yes _____

If "yes," please list below the specific defect in each case.

Birth Defect	Who	When did this happen?	Relevant Circumstances

Do you have any brothers or sisters who died in infancy or childhood? _____

If yes, what was the cause? _____

Are there any known genetic diseases or conditions that run in your family? _____

Has anyone in your family, including yourself, experienced recurring and/or chronic physical symptoms that have not been evaluated by a physician? (Please include those symptoms that you may not consider serious.) Yes ___ No ___

Please explain: _____

For Office Use Only Code # _____ Signature _____

What do you hope to achieve by volunteering in the egg donor program (e.g., emotionally, financially): ___

What message would you like passed on to the recipient of your eggs/their offspring? _____

What helped you decide to become an egg donor? _____

How would you describe yourself? Please include a description of your personality and temperament: _____

Describe your philosophy of life: _____

What is your favorite book and/or movie? _____

What are some of your favorite things or some things you might collect? (e.g. favorite flower, music, animals) _____

What do you see yourself doing in the next 5-10 years? _____

What would you like your recipient couple to know about you that has not already been asked? _____

Your Childhood

Describe yourself as a child (e.g., personality, health, happiness, etc.) _____

What was it like growing up in your family? _____

What religion did you belong to as a child? _____

What is your earliest memory as a child? _____

What problems did you have as a child (e.g., health, allergies, learning, social, etc.)? _____

When I was a child:

My favorite thing to do was: _____

At home I was expected to: _____

My parents were strict about: _____

My parents taught me to value: _____

What I loved most about my father was: _____

What I loved most about my mother was: _____

My favorite relatives were: _____

I loved to visit: _____

In comparison to others I was: _____

Your teenage years:

Describe yourself as a teenager: _____

Describe your achievements: _____

Did you do poorly at anything? _____

Did you have any problems as a teenager (e.g., health, acne, social, educational, etc.)? _____
